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Progress Through Partnership

Medicaid
Medicare
Management Institute

HEALTH CARE FINANCING ADMINISTRATION MARCH, 1981 ISSUE #3

MEDICAID MEDICARE EXCHANGE

HCFA GETS NEW ADMINISTRATOR

Carolyne K. Davis, Ph.D., is the first woman to be Administrator of the Health Care Financing Administration. Formerly the Associate Vice President for Academic Affairs at the University of Michigan, Dr. Davis had held that post since 1975. Dr. Davis was also Dean for that University's School of Nursing from 1973 through 1975.

Dr. Davis spent about ten years at the Syracuse (NY) University School of Nursing, advancing from a lecturer in pediatric nursing to the post of chair of the Baccalaureate Program at that school.

Among her professional affiliations, Dr. Davis includes: Upstate Health Association's Board of Directors from 1967-73,where she was Chair of the Nursing Education Committee 1968-71, and member of the Vice President Board 1972-73. During 1971-73, she was a member of Fayetteville-Manlius School Board, and a Fellow of the American Academy of Nursing. She is a member of the Board of Directors of the National League of Nursing.

Born in Penn Yan, New York, Dr. Davis has a B.S. in Nursing from John Hopkins University, and an M.S. in Nursing and a Ph.D. in Higher Education Administration, both from Syracuse University.

Dr. Davis succeeds Dr. Paul Willging who had been Acting Administrator after the resignation of the Administrator, Howard Newman, in January. Dr. Willging will now be Acting Deputy Administrator.

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FIRST PART A FIXED-PRICE CONTRACT

On November 10, 1980, Blue Cross Hospital Service, Inc. of St. Louis was awarded a three year fixed-price contract to process Medicare Part A claims in the State of Missouri and the Kansas City metropolitan area. This represents HCFA's first experiment in selecting, through competitive bid, one fiscal agent to cover an area formerly serviced by multiple Medicare intermediaries. Blue Cross of St. Louis will assume all intermediary responsibilities July 1, 1981.

This experiment will test the cost benefit effect and other administrative efficiencies derived from one organization serving as Medicare Part A intermediary for these areas, compared to five different contractors previously. HCFA projects potential administrative savings of $2 million initially from this contracting initiative.

Continued on page 20

MEDICARE CONSULTATIVE ACTIVITIES

by: PAUL BELLER

This column covers significant activities of Medicare carriers and intermediaries within the consultative process. It includes highlights of meetings, conferences, technical advisory groups and significant actions taken as a result of these communications between HCFA and the Medicare contractors. Questions concerning this column should be directed to Paul Beller, M/MMI, 301-594-9455, FTS 934-9455.

ACTIONS RESULTING FROM THE FISCAL INTERMEDIARY GROUP (FIG) MEETING SEPTEMBER 9-10, 1980

The Bureau of Program Operations (BPO) has responded by letter to the Fiscal Intermediary Group (FIG) on the performance issues raised at the September meeting. The letter includes changes made in the scoring system, in response to intermediary concerns.

A special meeting of the Provider Reimbursement and Audit TAG was held November 12-13, to address problems raised at the FIG meeting concerning the Cost Report Evaluation Program (CREP). The Bureau of Quality Control (BQC) has also communicated its views on CREP in a memorandum directed to BPO, dated November 20, 1980. These problems have also been reviewed by the Directors of the Bureau of Program Policy, BPO and BQC.

A (FIG) meeting was held in Baltimore on March 12, 1981. Details of this meeting will be given in the next issue of the Exchange.

ACTIONS RESULTING FROM THE CARRIER REPRESENTATIVE GROUP (CRG) MEETING

A need to strengthen the Carrier Technical Advisory Group (TAG) structure was discussed October 2 at the CRG meeting. As a result, a meeting was held in Chicago, on November 20, between the co-chairpersons of the Carrier Representative Group (CRG), the Fiscal Intermediary Group (FIG), the Acting BPO Director and senior staff of the Medicaid/Medicare Management Institute. This led to development of TAG procedures to strengthen the process and provide for more uniform application. Once the TAG procedures are completed, they will be widely distributed to Medicare contractors and HCFA staff.

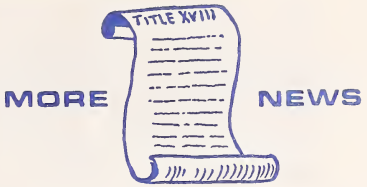
CRG representatives attended a Part A Performance Standards and Evaluation TAG meeting December 11-12 to learn how the ranking system for evaluating intermediary performance will operate. A carrier ranking system is to be developed that will have similar characteristics.

CARRIER REPRESENTATIVE GROUP MEETING FEBRUARY 6, 1981

This meeting's primary focus was on the implementation of the Omnibus Budget Reconciliation Bill (P.L. 96-499). Major initiatives will be required by HCFA and the Medicare contractors. HCFA will issue both interim and final instructions towards implementing the provisions of this legislation. There will also be considerable technical advisory group activity. A work plan is being developed to provide both HCFA and the Medicare contractors with a guide, including a listing of priorities and timeframes.

There was also considerable discussion of the budget for Medicare contractors for fiscal years 81 and 82. HCFA and the Medicare contractors are seeking to identify program areas of low priority that may not have to be implemented. This may provide some relief to the budgetary constraints.

CRG and FIG co-chairpersons and HCFA have begun planning for the next Medicare Contractor's Conference, to be held in Baltimore, September 1-2, 1981. The next CRG meeting is scheduled for May 14, 1981, in Baltimore.



TRANSFER OF BILL PROCESSING RESPONSIBILITIES

HCFA has begun to transfer the responsibility for processing Medicare claims for emergency services in foreign and nonparticipating domestic hospitals from its regional offices to designated regional intermediaries. The transfer has been accomplished successfully in the Boston, Dallas and Seattle regions; all regions should have made the transfer by June 30, 1981.

This change should free HCFA staff for broader responsibilities and simplify the billing process for those claims. Using a single contractor to process these claims should permit faster payment, and will improve beneficiary services. Some Medicare beneficiaries incurred significant debts for emergency care in foreign or nonparticipating domestic hospitals, paying for such services out of personal funds. Contact: Anita Heygster, 301-594-9131, FIS 934-9131.

STATE BUY-IN AGREEMENTS

Public Law 96-499, enacted December 5, 1980, allows a State to request a buy-in agreement for Medicare coverage of their Medicaid recipients, or to modify its present agreement to include a coverage group broader than covered under its present buy-in agreement. Under the law, States have until the end of calendar year 1981 to seek or modify a buy-in agreement.

Currently, four States and three jurisdictions have no buy-in agreements (Alaska, Oregon, Louisiana, Wyoming, Puerto Rico, American Samoa and the Northern Marianas); 21 States are eligible to expand their current agreements. Contact: Herman Kresh, 301-594-9818, FTS 934-9818.

MEDICARE

DIAGNOSTIC AND SURGICAL DATA STUDY

HCFA's Office of Research, Demonstration, and Statistics is conducting a study to assess, monitor, and improve the accuracy of data on diagnoses and surgical procedures. These procedures are reported for hospital inpatients on the Medicare Part A claim forms (HCFA-1453, items 17 and 18) for the Medicare Statistical Sample (a 20 percent sample of all beneficiaries based on the terminal digit of the health insurance number). Accurate diagnostic and surgical data on hospital stays of Medicare patients are essential to HCFA administrative and research functions.

The data are used in the MEDPAR reports, profiles of hospital utilization. PSROs and health systems agencies use these profiles for their utilization review and health planning activities. Accurate data are also necessary for the intermediaries to carry out their responsibility to review hospital claims before payment. The data also are being used in evaluation of such HCFA programs as the PSRO and the second surgical opinion. The data serves as the bases of internal research efforts, including studies of geographic variation in rates of surgery, length of pre- and post-operative stays and post-operative mortality rates.

A potentially important future use of the diagnostic and surgical data is case mix determination for hospital reimbursement. For example, Section 223 of the 1972 Amendments to the Social Security Act limits reimbursement for certain categories of hospital costs. Case mix data could be incorporated into reimbursement limits to reflect inter-hospital variations in resource use, due to variations in case severity.

The purposes of the current project are to assess current levels of accuracy and to identify effective techniques for improving the quality of the diagnostic and surgical information in the Medicare Statistical System. To achieve this, the project has five major activities:

First - Implement a pilot demonstration in five intermediary areas to assess the effectiveness of a limited number of changes in the claims reporting system.

Second - Survey and assess throughout the nation, all systems used to transmit diagnostic and surgical information from hospital medical records through the fiscal intermediary to the HCFA Medicare Statistical System.

Third - Evaluate the quality of the data throughout the nation, and relate the sources of error to the features of the systems for obtaining and transmitting the diagnostic and surgical information.

Fourth - Design a permanent system to monitor the quality of the diagnostic and surgical data being submitted, and to institute corrective action where indicated, and then,

Fifth - Develop recommendations for both minor and major modifications to the system for obtaining and transmitting diagnostic and surgical information, and then conduct a test of recommended system changes in a limited number of sites and evaluate the effectiveness of the changes in improving data quality.

Continued on page 5

Medicare Data Study - continued

There has been good progress in the pilot demonstration. Maryland, Florida, Texas, Colorado, and Arizona are participating in the demonstration. The national survey of all intermediaries and a sample of hospitals will begin in early 1981.

The study has been made both necessary and possible by the increasing automation of claims review, increases in submission of claims by the hospitals in machine readable form, the near universal implementation of ICD-9-CM as the classification system for diagnoses in hospitals and HCFA's commitment to adopting the uniform hospital discharge data set for Medicare. Contact: Harry Savitt, 301-594-7624, FTS 934-7624.

MMMI EVENTS

State Medicaid Directors' Conference
April 13-15 Philadelphia, PA

Contact: Ed Palder
301-594-8940, FTS 934-8940

PSRO Workshops
April 28-30 (postponed) Kansas City, MO
May 19-21 (tentative) San Diego, CA

Contact: Beulah Williamson
301-594-8844, FTS 934-8844

Medicaid-Title IV-D Workshops
April 28-29 Dallas, TX
To be Announced Boston, MA

Contact: Ben Holmes
301-594-9523, FTS 934-9523

Medicaid Eligibility Policy Workshops
May 4-6 Baltimore, MD
Week of May 18 (tentative) California
June 6-9 Kansas City, MO

Contact: Marlene Jones
301-594-8945, FTS 934-8945

IPR/MR Teams Training Workshop
May 5-7 Philadelphia, PA

Contact: Beulah Williamson
301-594-8844, FTS 934-8844

Carrier Representative Group Meeting
May 14 Baltimore, MD

Contact: Paul Beller
301-594-9455, FTS 934-9455

MMIS Conference
June 2-4 Kansas City, MO

Contact: Marlene Jones
301-594-8945, FTS 934-8945

Medicare Contractors' Conference
September 1-2 Baltimore, MD

Contact: Paul Beller
301-594-9455, FTS 934-9455

WATCH THIS SPACE FOR ANNOUNCEMENT OF ADDITIONAL PROGRAMS.

MEDICARE PREMIUM BILLING AND COLLECTION FUNCTIONS CENTRALIZED

In November 1980, HCFA reached agreement with the Social Security Administration to transfer the Medicare premium collection and concomitant functions to HCFA. Currently, negotiations are underway with SSA on the exact functions that will be brought over to HCFA.

By centralizing premium collections in one location, HCFA will realize a savings of $900,000 - $1,500,000 per year in costs, with a cut in processing time of six to seven days.

About 25,317,800 Part B enrollees have their premiums deducted from their monthly Social Security checks. Medicare beneficiaries not receiving Social Security (SS) checks pay their Part B Medicare premiums through other organizations. The Railroad Retirement Board and the Office of Personnel Management collect Part B premiums from their annuitants; through agreements with States and private employers, another large group have Medicare premiums paid on their behalf. About 825,000 Medicare beneficiaries are billed directly for premiums at a cost of about $103 million yearly. This total includes the 17,500 individuals purchasing Part A (hospital) insurance. The transfer of Medicare premium billing and collection covers those beneficiaries billed directly for their Medicare premiums.

Since 1966 the Medicare premium collection has been housed in eight SSA program service centers nationwide. Currently, Medicare premium bills (an 80 column punchcard) are sent from a central location in Baltimore to billable enrollees in three billing cycles. Beneficiary premium payments are sent to SSA's program service centers via return envelopes enclosed with each bill. The centers now process these remittances and input transactions to HCFA's Billing and Collection Master record. They also respond to Medicare inquiries.

The Treasury Department, primary trustee of the Medicare Trust Funds, assumes joint responsibility for collections. Treasury has agreed to share about $100,000 of the processing expenses for the centralized collection (projected to cost approximately $700,000 per annum). HCFA will enter into an interagency agreement with the Department of the Treasury to jointly issue an RFP, evaluate, select a vendor, and monitor the centralized operation.

Centralization of premium collections will be carried out under a contract with a financial institution. Agreements of this type are known in the banking community as "lock box" contracts. Up to 20 times a day, the incoming premium payments will be picked up from a post office box and processed by the bank; payments will be taped and transmitted to HCFA for entry to the billing collection master. All premiums received will be fully processed within 24 hours, with most premiums processed on the day received. With this approach, a savings will be achieved because all incoming premiums will be deposited with the Treasury Department on the day received and begin to accrue interest.

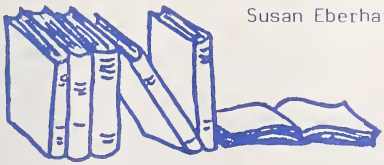
The premium collection operation is expected to improve service to beneficiaries by accelerating premium processing. Since trust fund monies will be deposited more rapidly, HCFA will be able to invest the collected funds much sooner than at present. The new operation will significantly reduce the cost of collections and provide a more practical means of direct premium collections.

As a part of the centralization efforts, HCFA will establish a unit in Baltimore to process correspondence received with payments as well as any premium collection exceptions.

Continued on page 7

Trainers... Take Note!

Medicare/Medicaid, Which is Which? is ready for distribution both in 3/4" videocassette and 16mm film. Call your HCFA regional office if you want to borrow this excellent training tool. "Trainers ... Take Note!" alerted you to this new audiovisual in the October issue of the Medicaid Medicare Exchange. The videocassette has been used with great success both with HCFA staff in Baltimore and with staff in Social Security district offices around the country. Medicare/Medicaid, Which is Which? describes how both programs are administered, who can participate in them, how they are financed and claims are processed. Finally, viewers are instructed on where to go for information about the programs. The Discussion Leader's Guide, which accompanies the audiovisual, reviews the basic elements of the film and can serve as the basis for a more indepth discussion of Medicare and Medicaid. Any questions regarding this audiovisual may be directed to Joseph Boston, M/MMI, 301-594-8648, FTS 934-8648.



Susan Eberhard

Medicare Functions Centralized - continued

The premium collection operation should be centralized in HCFA by the end of this fiscal year. For further information, contact Castomal Alexander, 301-594-9882, FTS 934-9882.

TELEPHONE

FAIR HEARINGS

As a beneficiary services initiative, the Dallas regional office this summer authorized the Texas Medicare carrier to hold selected Part B hearings by telephone. Presently, about ten percent of all Medicare fair hearings in Texas are conducted by telephone.

This has proven beneficial to aged and ill beneficiaries, and to physicians, since it permits the doctors to schedule their patients around a telephone call, rather than spending several hours away from the office. "Telephone" hearings have resulted in considerable savings to the carrier as well. From June through December 1980, the hearing officers spent approximately 27 hours conducting 86 hearings by telephone. Some 57 1/2 days would have been required to travel to various parts of Texas to conduct hearings. Savings on mileage alone exceeded $5,600 during this period.

Based on these positive results, other carriers in the Dallas region have been authorized to implement this procedure. Questions or comments concerning this experiment can be directed to Joe Christenberry, FTS 729-6441 or Jo Batchelor, FTS 729-6401.

MEDICARE CARRIER & INTERMEDIARY SYSTEMS SECURITY

More than half of the Medicare carriers and intermediaries have completed risk analyses of their operations. As of January 1 of this year, 72 carriers and intermediaries had finished their risk analyses, and 30 contractors had their risk analyses in process. Some 15 contractors have yet to start the process.

Risk analysis is a systematic method for anticipating mishaps and possible threats to Medicare personal data, assets, and funds. Among the mishaps and threats considered in risk analysis are fire, earthquake, flood, accidental error, unauthorized disclosure of medical records, theft, and fraud. A recent example from reality: volcanic ash fallout from Mount St. Helens' last year caused the Helena, Montana, Medicare claims processing office to close for two days.

A completed risk analysis results in recommended remedial measures. Proposed measures may be as simple as adding a lock to an interior door or posting an area off limits to unauthorized personnel; proposed safeguards may be as complex as installing a computer controlled plastic card-entry system or a sophisticated backup electrical power source. All proposed safeguards requiring additional funds undergo the HCFA budget process.

The systems security program is administered directly by the Medicare regional offices. The Systems Security and Testing Branch (SSTB) of the Division of Systems Review and Evaluation developed the information collection system for national monitoring of risk analysis and other systems security activities.

As the risk analysis project nears completion, the systems security program will now shift emphasis to contingency planning. Every Medicare carrier and intermediary is required to maintain and annually update a comprehensive plan to deal with such events as fire, flood, electrical power failure, strike, and civil disorder.

For further information on the Medicare carrier and intermediary systems security program, contact Alan Smith at 301-594-9135, FTS 934-9135.

EVALUATION OF MEDICARE CONTRACTORS

A workshop to refine the intermediary ranking system for Medicare contractors was held in Baltimore, November 18-19. The draft ranking methodology developed was presented to the Part A Performance Standards and Evaluation Technical Advisory Group for input on December 11-12. Representatives of Blue Cross plans and commercial insurance Medicare contractors participated.

For FY 81, the proposed evaluation system will distinguish various levels of performance based on criteria and standards scores and incorporates a three-tier approach. The first tier represents contractors meeting all criteria and standards requirements; tier two will reflect the contractors which meet the criteria but are substantially deficient in standards. Appearing on tier three are contractors not meeting minimum criteria requirements.

An Annual Contractor Evaluation Report is prepared for each individual contractor and is the official public document reflecting contractor performance. The ranking system is an internal tool, multi-purpose in nature, recognizing high levels of performance; identifying poor performance, and aiding in the development of experimental contracts.

A Part B ranking workshop is being considered for the Fall of 1981. Contact: Joan M. Smith, Office of Standards and Performance Evaluation 301-597-3454, FTS 987-3454.

MONTHLY CLAIMS REPORT

A Medicaid Claims Workload and Processing Times Report, published monthly, is available from HCFA's Division of Reports and Analysis. Each report is designed to provide current information on workloads as well as timeliness of claims processing activities. In January 1980, State agencies began to report this information in Part IV of the HCFA-120 (Monthly Statistical Report on Medical Care).

The information shown in each report is based on: a standard definition of a claim for each type of service category; claims processing time for State agencies determined using adjudication date instead of payment date, and inclusion of all paid claims and not just "clean" paid claims.

At a later date, these reports may be prepared on a quarterly basis instead of monthly. For further information or to obtain a copy of a specific report at no cost, contact Ellen Gochnauer, 301-594-3847, FTS 934-3847.

SUPPLEMENTAL HEALTH INSURANCE PANEL ESTABLISHED

The Supplemental Health Insurance Panel required by P.L. 96-265 to evaluate State regulatory programs for Medigap policies has now been established.

The Secretary of Health and Human Services serves as Chairperson of the panel of four State Commissioners of Insurance, appointed by the President. The Commissioners are: Roger Day (Utah); Joseph C. Mike (Connecticut); Susan Mitchell (Wisconsin); and, William H. L. Woodyard, III (Arkansas).

This panel will determine if a State's legislation and regulations meet or exceed the standards contained in the Medigap law. The voluntary certification program will not be applicable to those States with standards meeting the requirements, and policies approved for issuance in such a State will be deemed to meet the minimum standards contained in the law.

The panel is required to submit a report to Congress by January 1982, identifying those States not expected to establish a qualified State regulatory program by July 1, 1982. The Federal voluntary certification program would be put into effect on that date in States that are so identified.

The initial meeting of the panel was held in New York, December 3, 1980, to discuss procedural issues related to carrying out its functions. A date for the second panel meeting has not been decided. Contact: Robert Silva, Director, Medigap Operations Staff, 301-594-9412, FTS 934-9412.

ACTION TRANSMITTALS

These Action Transmittals have been issued by HCFA in December, January, and February. States desiring copies may order them by calling 301-594-5519, FTS 934-5519.

AT-80-83 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated, or Where Effectuated Sanction Was Withdrawn (Refer to Sections 506(f)(2), 1862(d), 1862(e), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

AT-80-84 Title XIX, Social Security Act: Deeming of Income Between Spouses in 1902(f) States (Refer to 42 CFR 435.602, 435.734, 436.602, 436.711 and 436.821)

AT-80-85 Title XIX, Social Security Act: Time Requirements for Reviews and Reports in the Medicaid Quality Control (MQC) Program (Refer to 42 CFR 431.800)

AT-80-86 Title XIX, Social Security Act: Medicaid Reimbursement for Services Furnished by Rural Health Clinics (RHCs) (Refer to 42 CFR Parts 405 and 447)

AT-80-87 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated, or Where Effectuated Sanction Was Withdrawn (Refer to Section 506(f)(2), 1862(d), 1862(e), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

AT-80-88 Clarification of Effective Date of Medicaid Action Transmittal (AT) 80-44 and Instructions on Changing Original State Findings for Medicaid Quality Control (MQC) Based on Medicaid AT-80-44--ACTION (Refer to Medicaid Action Transmittal 80-44 Dated July 1980 and Medicaid Action Transmittal 80-10 Dated February 28, 1980)

AT-80-89 Medicaid Quality Control (MQC) Eligibility Review of Supplemental Security Income (SSI) Cash Recipients Eligible for Medicaid in States Providing Medicaid Coverage to All SSI Recipients

AT-80-90 Title XIX, Social Security Act: Limitations on Payment or Reimbursement for Drugs (Refer to 42 CFR 447.332; SRS-AT-75-72 (MSA) August 15, 1975)

AT-80-91 Medicaid Quality Control Instructions for Reviewing and Citing Dollar and Nondollar Errors in the Claims Processing Review (Refer to 42 CFR, Parts 431, 440, 441, 447, and 455)

AT-80-92 Additional Information on Reviewing for Error Codes 740-04 (Claims for SNF or ICF Where Patient Not Certified) and 740-05 (SNF or ICF Charge After Patient Certification Discontinued) (Refer to Section 1903(a)(1)(A); 42 CFR 456.60; 42 CFR 456.160; 42 CFR 456.260; and 42 CFR 456.360)

AT-80-93 Implementation of Guidelines for Developmental Assessment (Refer to 42 CFR 441.56(a)(3))

AT-80-94 Clarification of Instructions for Adjusting Hospitals and Skilled Nursing Facilities Interim Payments for Malpractice Costs - Follow-up to HCFA Action Transmittal No. 80-32, Dated April 24, 1980

AT-81-1 Title XIX, Social Security Act: Administrative Sanctions Under the Medicaid Program (Refer to 42 CFR Part 455)

AT-81-2 Medical Assistance Manual: Services and Payment in Medical Assistance Programs; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Eligible Individuals Under Age 21; Reports; Quarterly Child Health Status Report (HCFA-156) (Refer to 42 CFR 431.16)

AT-81-3 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated, or Where Effectuated Sanction was Withdrawn (Refer to Sections 506(f)(2), 1862(d), 1862(e), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

AT-81-4 Title XIX, Social Security Act: Deeming of Income Between Spouses in 1902(f) States (Refer to 42 CFR 435.121, 435.602, 435.734, 436.602, 436.711 and 435.821)

AT-81-5 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated, or Where Effectuated Sanction was Withdrawn (Refer to Sections 506(f)(2), 1862(d), 1862(e), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

AT-81-6 Title XIX, Social Security Act: Limitation on Payment or Reimbursement for Drugs (Refer to 42 CFR 447.332; SRS-AT-75-72 (MSA) August 15, 1975)

AT-81-7 Title XIX, Social Security Act: Persons Considered to be Blind or Disabled Individuals Receiving SSI (Refer to 42 CFR 435.3, 435.4, and 435.120)

AT-81-8 Interpretation of the Phrase "...by or under the direction of a physician..." Contained in 42 CFR 440.90 as it Relates to the Provision of Alcohol Abuse Treatment and Services in Free-Standing Clinics Under Medicaid -- Information (Refer to 422 CFR 440.90 and Information Memorandum MSA-IM-16 dated July 31, 1972)

AT-81-9 Resumption of State Agency Responsibilities Following the Defunding of a Professional Standards Review Organization (PSRO) (Refer to Sections 1102 and 1153 of the Social Security Act; 42 CFR 463.27)

AT-81-10 Title XIX of the Social Security Act: Preprinted State Plan Amendment on Persons Considered to be Blind or Disabled Individuals Receiving SSI (Refer to 42 CFR 435.3, 435.4 and 435.120; HCFA-AT-81-7, February, 1981; Federal Register January 22, 1981, 46 FR 6903, effective January 1, 1981)

AT-81-11 Title XIX, Social Security Act: Deeming of Income Between Spouses (Refer to 42 CFR Parts 435 and 436; HCFA-AT-81-4, February, 1981; Federal Register 46 FR 82254, effective December 15, 1980)

Legislative Ledger

H.J. Resolution 644, the continuing resolution that provides appropriations for several agencies, including DHHS, through June 5, 1981, was signed into law (P.L. 96-536) December 16. The previous continuing resolution (H.J. 610) expired December 15. The funding levels (in millions) are: Medicaid $15,877; Medicare $9,577, and PSRO $173.7. P.L. 96-536 contains the same Medicaid abortion funding restrictions, in addition to restricting the Department from implementing proposed regulations on conditions of participation of skilled nursing facilities and intermediate care facilities prior to Congressional receipt of revised cost estimates from DHHS and a GAO impact report.

On October 10, the President signed into law the Maine Indian Claims Settlement Act of 1980 (P.L. 96-420). This law provides for the settlement of land claims raised by the Passamaquoddy Tribe, the Penobscott Nation, and the Houlton Band of Maliseet Indians in Maine. P.L. 96-420 allows $54.5 million to be used to provide land for these tribes and $27 million for establishing a "Settlement Fund" for the Passamaquoddy Tribe and the Penobscott Nation. P.L. 96-420 also specifies that these are Federally recognized Indian tribes and are eligible to receive all Federal financial benefits available to other Indians. Income increases resulting from the land settlement cannot be used t deny Medicaid benefits to individuals otherwise so entitled.

The House and Senate adjourned December 16, ending the Second Session of the 96th Congress. The First Session of the 97th Congress began January 5.

For further information on these or other HCFA legislative issues, call Richard Chambers, HCFA's Legislative Reference Office, 202-426-3717.

INFORMATION MEMORANDUMS

IM-80-36 Implementation of EPSDT QC Reviews

IM-80-37 EPSDT QC Requirements for Cases Where the AFDC Payment Has Been Held or Suspended

IM-81-1 State Medicaid Directors' Annual Conference

IM-81-2 Medicaid/Health Insurance Carrier Data Matching

IM-81-3 National Conference on Early and Periodic Screening, Diagnosis, ar Treatment (EPSDT)

IM-81-4 National Conference on Management Information Systems (MIS) - Benefits to Management, Kansas City, Missouri, June 2-4, 1981

PROGRAM INTEGRITY DIRECTORS' CONFERENCE

Program Integrity regional office directors, deputy directors and representatives of the Office of Program Validation (OPV) attended a conference at the Lord Baltimore Hotel on February 10-12. Attendees discussed validation reviews conducted during FY 80 and those proposed for FY 81, as well as other validation issues, regional relationship with State agencies, contractors/PSROs and other HCFA components. Special studies, and legislative and policy issues for FY 81 and 82, were also discussed.

Department of Justice Civil Division representatives and OPV specialists discussed newly developed initiatives in civil fraud and administrative sanctions. Attendees were also informed of new procedures for developing and processing administrative sanctions in medical abuse situations. Contact: Linda Rudolph, 301-597-2674, FTS 987-2674.

NEW USE OF UB-16

After testing the Uniform Institutional Provider Billing Form (UB-16) in Ohio, the Hospital Association (OHA) in that State asked to expand the use of the form to hospital-based physicians' Medicare billing. Florida, Arizona, Connecticut, and Nevada are also participating in testing this form but not for use by hospital-based physicians. UB-16 is sponsored by the American Hospital Association.

Nationwide Insurance Company, the Part B contractor for Ohio and also one of the five Part A contractors there, has agreed to accept the UB-16 in lieu of the HCFA-1554 for approximately 10 to 15 percent of its HCFA-1554 workload (about 100 to 150 claims per day). Nationwide will develop appropriate billing instructions for both OHA and HCFA approval and will report on its experience in this subtest. Start of a six-month test of the new procedures is anticipated for early 1981. Contact: Madeline Ulrich, 301-594-9136, FTS 934-9136.

INCREASE IN MEDICARE PREMIUMS AND DEDUCTIBLES

Effective January 1, Medicare hospital deductibles under Part A rose from $180 to $204 for the first 60 days of services. Coinsurance for the 61st to the 90th day increased from $45 a day to $51. Cost for the 60 reserve days went up to $102 a day. Coinsurance for services provided at a skilled nursing facility during the 21st through the 100th day of stay also increased from $22.50 to $25.50 a day. These increases are a result of the rising cost for health care.

Medicare's regular Part B monthly premium of $9.60 will rise to $11.00 July 1, 1981. Those Medicare beneficiaries paying higher Part B premiums because they declined coverage initially will also pay increased premiums on that date, which could be up to 140 percent of the base premium.

For those persons not covered by social security, but who purchase Medicare Part A coverage, the monthly premium rate of $78 will rise to $89 beginning July 1. Late enrollees for Part A will see their monthly premiums increase as much as 70 percent. Higher Part B premiums will also apply for this group. For further information, contact Jean Hendricks, 301-594-9604, FTS 934-9604.

REGULATION

Following are recent HCFA regulations of interest to Medicaid and Medicare program managers. Questions may be directed to the contact persons listed with each regulation.

Medicare Program: Withholding of Payments to Practitioners, Providers, and Suppliers of Services - Proposed Rule
12/01/80 Federal Register
Contact: Irwin Cohen, 301-594-8213, FTS 934-8213

Medicare and Medicaid Programs: Approval of Incorporations by Reference
12/01/80 Federal Register
Contact: Rose Anne Lawson, 202-523-4534

Medicare Program: Collections of Unpaid Medicare Premiums - Final Regulation with Comment Period
12/01/80 Federal Register
Contact: Harold Fishman, 301-594-9077, FTS 934-9077

Medicare and Medicaid Programs: Pharmaceutical Reimbursement Board; Suspension of Maximum Allowable Cost Limits - Final Notice
12/03/80 Federal Register
Contact: Charles Spalding, 301-594-5403, FTS 934-5403

Medicare Program: Reimbursement of Hospital-Based Physicians - Notice
12/08/80 Federal Register
Contact: Leonard Peshkin, 301-594-1115, FTS 934-1115

Medicare and Medicaid Programs: National Professional Standards Review Council; Meeting
12/10/80 Federal Register
Contact: Cleo Hancock, Jr., 202-245-6097

Medicaid Program: Deeming of Income Between Spouses - Final Regulation
12/15/80 Federal Register
Contact: Dennis McNown, 301-594-8221, FTS 934-8221

Medicare and Medicaid Programs: Conditions of Participation for Hospitals; Conditions for Coverage of Services of Independent Laboratories; Transfusion and Blood Banking Services - Regulation Proposal
12/19/80 Federal Register
Contact: Royal A. Crystal, 301-594-7910, FTS 934-7910

Medicaid Program: Medical Assistance Programs; Title XIX Administrative Sanctions - Proposed Rule
12/19/80 Federal Register
Contact: Irwin Cohen, 301-594-8213, FTS 934-8213

Medicare and Medicaid Programs: Improving Government Regulations; Semiannual Agenda of Regulations
12/19/80 Federal Register
Contact: Glenn Kamber, 202-245-3160

Medicare Program: Reimbursement for Costs of Approved Internship and Residency Programs; OMB Review of Reporting Requirements - General Notice
12/22/80 Federal Register
Contact: William Goeller, 301-597-1802, FTS 987-1802

Medicare and Medicaid Programs: Limit on Payment for Services of Independent Rural Health Clinics - Proposed Notice
12/23/80 Federal Register
Contact: Bernadette Schumaker, 301-597-1048, FTS 987-1048

Medicare Program: Monthly Actuarial Rates and Monthly Premium Rates - Final Notice
12/24/80 Federal Register
Contact: Guy King, 301-594-2826, FTS 934-2826

Medicare and Medicaid Programs: Pharmaceutical Reimbursement Board, Proposed MACs and Announcement of Public Hearing - Proposed Notice
12/24/80 Federal Register
Contact: Charles Spalding, 301-594-5403, FTS 934-5403

Medicare Program: Premium Rate for the Uninsured Aged - Final Notice
12/24/80 Federal Register
Contact: Charles Spalding, 301-594-5403, FTS 934-5403

Medicaid Program: Entitlement of Individuals Receiving Cash Assistance Under the Foster Care Maintenance Payments Program or the Adoption Assistance Program - Proposed Rule
12/31/80 Federal Register
Contact: Dennis McNown, 301-594-8220, FTS 934-8220

Medicare and Medicaid Programs: Conditions of Participation; Hospitals (Correction to Proposed Regulation) - Correction Notice
01/05/81 Federal Register
Contact: Margaret VanAmringe, 301-594-9712, FTS 934-9712

Medicaid Program: Plans of Correction for Intermediate Care Facilities for the Mentally Retarded - Final Regulation with Comment Period
01/06/81 Federal Register
Contact: Dr. Wayne Smith, 301-594-7651, FTS 934-7651

Medicare and Medicaid Programs: Conditions for Coverage of Suppliers of ESRD Services; Self-Dialysis and Home Dialysis Training - Notice of Proposed Rulemaking
01/15/81 Federal Register
Contact: Margaret VanAmringe, 301-594-9712, FTS 934-9712

Medicare Program: Reimbursement for Costs Incurred in Relation to Union Activities - Final Notice
01/16/81 Federal Register
Contact: William Goeller, 301-597-1802, FTS 987-1802

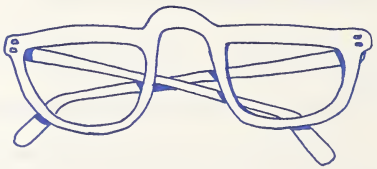
Continued on page 18

HCFA PROGRAM VALIDATION EFFORTS

FY 80 validation reviews completed by central and regional components of the Office of Program Validation, BQC resulted in an estimated savings of $145,037,618 to Medicare and Medicaid. The reported savings represent a combination of overpayments to individual practitioners, providers, and other suppliers by State Medicaid agencies and Medicare contractors.

Reports of the 195 reviews conducted by HCFA central and regional offices have been prepared and cover Systematic Abuse Reviews (SARs), Aberrant Cost Studies (ACS), and Program Implementation Reviews (PIRs) included in the validation studies. SARs center on providers reimbursed on a reasonable charge or fee related basis, ACS focus on providers reimbursed on a cost or cost related basis, and PIRs examine the appropriateness of existing policies.

Several of the FY 80 reviews showed significant results. Reviews of home health agencies, nursing home rates, and comprehensive health centers produced an estimated overpayment of approximately $30.8 million. Reviews conducted at the end-stage renal disease facilities revealed that changes in reimbursement policy could result in approximately $48.5 million savings to the programs. Contact: Linda Rudolph, 301-597-2674, FTS 987-2674.



CHANGE IN VISION CARE BENEFITS

Under P.L. 96-499, Section 937, Medicare will now cover examinations by optometrists to determine the eye health condition for beneficiaries who have had a cataract removed. In the past, such an examination was covered only if performed by an opthalmologist.

Approximately 400,000 older adults have cataract surgery every year. About 95 percent are able to return to routine activities after adjusting to new glasses or contact lenses.

According to the American Optometric Association (AOA), the nation's 21,500 doctors of optometry are located in 6,368 municipalities and provide 60 percent of the nation's vision care. Opthalmologists number 10,750 and are located in 2,281 municipalities, mostly urban centers.

The new law will be of great benefit to post surgical cataract patients who do not have easy access to an opthalmologist and to those who prefer to go to an optometrist for vision care, asserts AOA.

Personnel

MEDICARE

INTERMEDIARY/CARRIER DIRECTORY UPDATE

Part I - Blue Cross Plans

Blue Cross of Northeastern Pennsylvania - Add Gilbert D. Tough, Vice President - Operations
Blue Cross of Kansas City - Add John T. Hines, Director of Medicare

Part II - Blue Shield Plans

Delete South Dakota Medical Service, Inc.
Blue Shield of Kansas City - Add John T. Hines, Director of Medicare

Part III - Commercial

Occidental Life Insurance Company - Richard Hedlund, 2nd Vice President and Chief Medicare Administrator (replacing Peter Mills)

Part IV - Intermediary Numerical Listing - Blue Cross Plans

Add - Intermediary Number 00308, New York Blue Cross Medicare "A", Syracuse, New York

Part V - Part B Medicare Claims Addresses

South Dakota - Claims should now be addressed to:
Medicare
Blue Shield of North Dakota
301 Eighth Street, South
Fargo, North Dakota 58102

MEDICAID

New Single State Agency Directors

John LaFaver - Montana Department of Social and Rehabilitation Services
S. H. Torvik - Wyoming Department of Health and Social Services

New Medical Assistance Unit Directors

Russell Schwartz - New York Department of Social Services
Robert Treibley (Acting) - Virginia Department of Health
Thomas Gaylord - Minnesota Department of Public Welfare
Melvin Owens (Acting) - Utah Department of Health

HCFA

Office of Intergovernmental Affairs

Henry Spiegalblatt, Acting Director

Office of Congressional Affairs

Jake Culp, Acting Director

Regulation Review - continued from page 15

Medicare and Medicaid Programs: National Professional Standards Review Council, Request for Nomination of Members - PSRO Notice
01/16/81 Federal Register
Contact: Cleo Hancock, Jr., 202-245-6097

Medicare Program: Schedule of Target Reimbursement Rates for Institutions Furnishing Home Dialysis Supplies, Equipment, and Support Services - Final Notice
01/16/81 Federal Register
Contact: Bernadette Schumaker, 301-597-1048, FTS 987-1048

Medicare and Medicaid Programs: Privacy Act of 1974; Report of Altered System - Notice
01/16/81 Federal Register
Contact: Alan Friedlob, 301-597-2364, FTS 987-2364

Medicaid Program: Requirements Applicable to Sterilizations (Hysterectomies) - Proposed Rule
01/19/81 Federal Register
Contact: Raymond T. Johnson, 301-594-9370, FTS 934-9370

Medicare Program: Shared Services Organization and Cost to Related Organizations - Withdrawal Notice
01/19/81 Federal Register
Contact: Paul Trimble, 301-594-8640, FTS 934-8640

Medicaid Program: Entitlement of Individuals Receiving Cash Assistance Under the Foster Care Maintenance Payments Program or the Adoption Assistance Program - Correction Notice
01/19/81 Federal Register
Contact: Dennis McNown, 301-594-8220, FTS 934-8220

Medicare Program: Medigap - Certification of Medicare Supplemental Health Insurance Policies - Proposed Rule
01/21/81 Federal Register
Contact: Thomas Hoyer, 301-594-9690, FTS 934-9690

Medicare and Medicaid Programs: Supplemental Security Income, Medicaid and Social Security; Continuation of Benefits and Eligibility for Certain Severely Impaired Recipients Who Work - Interim Regulation with Comment Period
01/22/81 Federal Register
Contact: For SSI - Fred Miranda, 301-594-7341, FTS 934-7341; For Medicaid - Richard Cody, 301-594-9050, FTS 934-9050; For Title XX - Mrs. Johnnie Brooks, 202-472-4415

Medicare Program: Solicitation of Hospitals and Medical Centers to Participate in a Study of Health Transplants - Notice
01/22/81 Federal Register
Contact: Donald A. Young, M.D., 301-594-9690, FTS 934-9690

Medicare Program: Conditions of Participation for Skilled Nursing and Intermediate Care Facilities (Withdrawal of Secretarial Approval) - Notice
01/23/81 Federal Register
Contact: J. Richard Lenehan, Jr., 301-594-7651, FTS 934-7651

Continued on page 19

MANAGEMENT TRAINING

State and local Medicaid managers may be eligible for a new management training program if their duties also include AFDC functions.

SSA's Office of Family Assistance has contracted with the American Public Welfare Association to provide management training to State and local executives and managers of AFDC and AFDC support-related programs. Three university sites have been selected for the training: the University of Georgia at Athens, the University of Texas at Austin, and the University of Southern California at Los Angeles. Separate seminars are being developed for senior level State and local managers and for middle managers. Sessions will run from May to September.

Further information should be available through ordinary supervisory channels.

FIRST RURAL HEALTH CLINIC IN ARKANSAS

The Rector Medical Clinic became Arkansas' first RHC to be certified for coverage in the Medicare program in October 1980.

The Arkansas carrier had no reimbursement mechanism to process claims from these types of health suppliers and this delayed the certification of this clinic. A reimbursement mechanism is now established but is not expected to greatly increase the number of RHCs in Arkansas. Higher or alternative reimbursement from other sources is another reason the RHC program has not been more popular in Region VI States.

Nearly 400 rural health clinics (RHCs) have been certified nationwide. A final calendar year 1980 report showed the Dallas Region (VI) has 23 certified RHCs. Nineteen of these clinics are located in New Mexico. Contact: Linda Washington, Region VI, FTS 729-6301.

Regulation Review - continued from page 18

Medicare and Medicaid Programs: Schedules of Limits on Home Health Agency Costs Per Visit, Hospital Inpatient Routine Operating Costs and Skilled Nursing Facility Inpatient Routine Service Costs - General Notice
01/23/81 Federal Register
Contact: Carl Slutter, 301-594-9344, FTS 934-9344

Medicare and Medicaid Programs: Privacy Act of 1974; System of Records and Notice of Proposed Routine Uses - General Notice
01/23/81 Federal Register
Contact: Thomas Kickham, Ph.D., 301-594-7621, FTS 934-7621

Medicare and Medicaid Program: Privacy Act of 1974; Report of New System - General Notice
01/23/81 Federal Register
Contact: Spike Duzor, 301-597-2367, FTS 987-2367

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WORKERS' COMPENSATION INFORMATION ADDED TO MEDICARE RECORDS

HCFA's Bureau of Support Services recently began to add Workers' Compensation (WC) offset data from SSA's Master Beneficiary Record to the Medicare Master File. SSA records include cash WC awards only, to use in computing monthly disability payments. The existence of cash WC awards can indicate third party liability of State Workers' Compensation agencies for medical expenses.

Up to now, HCFA had depended on the beneficiary and provider claims and billing forms to indicate whether treatment was related to a work injury. HCFA was unable to determine if a beneficiary received a WC award from this information. Medicare is not responsible for hospital or medical expenses which could be reimbursed under State Workers' Compensation Award terms.

In April, HCFA will add WC data to all replies to intermediary and carrier queries concerning Medicare entitlement. This information will then be passed on to Medicare contractors to alert them of possible third party liability in cases when neither the patient nor the provider indicate job related injuries or diseases.

Instructions have been issued to all HCFA contractors explaining the query replies, the proper contractor response, and the varying degree of reliability of the trailers on a State-by-State basis. Contact: Bob Flagg, 301-594-8390, FTS 934-8390.

Department of Health and Human Services
Richard S. Schweiker, Secretary

Health Care Financing Administration
Carolyne K. Davis, Ph.D., Administrator

Bureau of Program Operations
Tera S. Younger, Acting Director

Medicaid/Medicare Management Institute
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Baltimore, MD 21235
301-594-8699
FTS-934-8699

First Part A Fixed-Price Contract - continued from front page

The switchover of multiple intermediary responsibilities to Blue Cross Hospital Service, Inc., is being carried out under the guidance of a Transition Committee composed of representatives from all affected Part A intermediaries, HCFA central office, and Kansas City regional office. This competitive procurement was initiated under Section 222 of P.L. 92-603, the 1972 amendments to the Social Security Act.

NOTICE-NOTICE-NOTICE

Four Bureau of Program Operations offices are now in a new location at 6300 Security Boulevard in Baltimore. Mail should be directed to particular offices as shown:

Office of the Bureau Director - 300 Meadows East Building
Executive/Management Offices - 360 Meadows East Building
Group Health Plans Operations Staff - 3-A-1 Meadows East Building
Office of Program Administration - 343 Meadows East Building